STRATEGIC MANAGEMENT SERVICES

# Home Health Fraud "Red Flags"

Richard P. Kusserow | February 2024

**Key Points:**

- **Home Health fraud remains among the highest DOJ and OIG enforcement priorities**
- **Major fraud categories: billing fraud, improper care/abuse and kickback**
- **"Red Flags" that suggest potential fraud**

Home health care has long been recognized as vulnerable to fraud, waste, and abuse. Medicare reimburses more than 11,000 home health care agencies for their services. They estimated that $10 billion of those payments—more than half of the total reimbursement—were improper or fraudulent. The potential for home health care fraud is so high that CMS has imposed moratoria on new home health agency enrollment in selected geographic areas at high risk for fraud. Most home health fraud involves home health agencies billing for services that were not provided, billing for services that were not medically necessary, or engaging in kickback schemes to generate referrals.

## Fraud Red Flags

- Beneficiaries without recent visits with their physicians to certify medically necessary care
- Home health care services provided without having followed a hospital or nursing home stay
- Home Health is not customarily justified when the primary diagnosis is diabetes or hypertension
- Orders signed by a physician who is not the patient's primary caregiver
- Multiple episodes of observation and assessment of chronic conditions
- Discharges followed by re-admissions without intervening change in the patient's condition
- Inconsistencies in the patient's treatment, such as a patient receiving home visits and skilled nursing while going to visit their primary care physician

## Fraudulent activities resulting in recent enforcement

- Upcoding the types of services provided to receive higher payment
- Submitting bills for patients who are not homebound
- Visits by home health staff that are medically unnecessary
- Home health visits that a doctor ordered but that a patient did not receive
- Billing for services and equipment unreceived by a patient

- Fake signatures on medical forms or equipment orders
- Pressure to accept items and services that are not necessary or that Medicare does not cover
- Home health services provided that were not ordered by a physician
- A home health agency that offers free goods or services in exchange for Medicare numbers
- Nurses lying about patients' conditions to make patients seem sicker than they actually are
- Falsely indicating that doctors and nurses are discussing patients' conditions and care
- Fake nurses' documentation regarding visits to make routine checkups appear to be necessary
- Agencies discharge patients and then re-admit them at the same agency or a related agency even when there is no intervening change in the patient's medical condition
- Billing Medicare for unnecessary services, such as home visits that are automatically scheduled on a monthly basis, tests, care plan oversight
- Using non-physician employees to document supporting unnecessary services
- Schemes involving kickbacks to generate business

It is advisable for the Compliance Officer to ensure that risk assessments address all the areas noted above.

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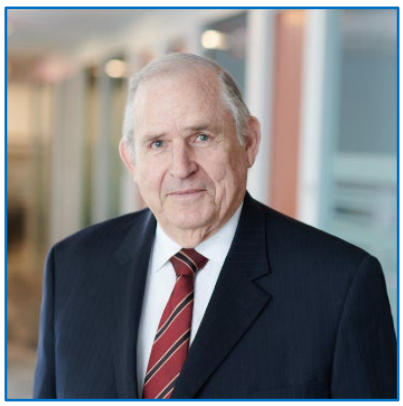

## About the Author

Richard P. Kusserow established Strategic Management Services, LLC, after retiring from being the DHHS Inspector General, and has assisted over 2,000 health care organizations and entities in developing, implementing and assessing compliance programs.